FILED
Court of Appeals
Division II
State of Washington
8/1/2022 12:21 PM

NO. 56768-7-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

VINCENT ROBERSON

Appellant,

v.

CHI FRANCISCAN, et al.,

Respondents.

BRIEF OF RESPONDENT SOUND INPATIENT PHYSICIANS, INC.

JOHNSON, GRAFFE, KEAY,
MONIZ & WICK, LLP
Brennen Johnson, No. 51665
Philip M. deMaine, No. 28389
Attorneys for Sound Inpatient Physicians, Inc.
2115 N. 30th St., Ste. 101
Tacoma, WA 98403
(253) 572-5373
brennenj@jgkmw.com

TABLE OF CONTENTS

TABLE OF CONTENTS i

TABLE OF AUTHORITIES iii

I. INTRODUCTION 1

II. RESTATEMENT OF ISSUES 2

III. RESTATEMENT OF THE CASE 3

A. Factual Background 3

B. Litigation Background 10

1. Dr. Kramer and Dr. Grabowski Prevail on Summary Judgment 10

2. ARNP Hahn's Deposition Reveals She Lacks Foundational Expertise or an Underlying Factual Basis for Her Opinions 12

3. Sound Inpatient Physicians, Inc. Prevails on Summary Judgment 22

IV. ARGUMENT 23

A. Competent Expert Testimony Was an Essential Element to Support Appellant's Claim of Medical Malpractice ..24

B. A Witness's Qualification to Offer Expert Medical Testimony is Determined by the Witness's Personal Training and Experience 31

C. Appellant's Sole Expert Witness was Unqualified to Opine on Essential Components of the Standard of Care or Medical Causation Specific to this Case 34

D. Appellant's Sole Expert Witness Admitted that Her Theory of Medical Causation was Purely Speculative and Lacked a Factual Basis 37

V. CONCLUSION.....41

VI. CERTIFICATE OF SERVICE.....43

TABLE OF AUTHORITIES

Cases

Boyer v. Morimoto, 10 Wn. App. 2d 506, 449 P.3d 285 (2019) 28

Branom v. State, 94 Wn. App. 964, 974 P.2d 335 (1999) 25

Frausto v. Yakima HMA, LLC, 188 Wn.2d 227, 393 P.3d 776 (2017) 29, 31, 32, 35

Guile v. Ballard Cmty. Hosp., 70 Wn. App. 18, 851 P.2d 689 (1993) 25

Harris v. Robert C. Groth, M.D., Inc., P.S., 99 Wn.2d 438, 663 P.2d 113 (1983) 31, 35

L.M. by & through Dussault v. Hamilton, 193 Wn.2d 113, 436 P.3d 803 (2019) 32

McKee v. Am. Home Prod. Corp., 113 Wn.2d 701, 782 P.2d 1045 (1989) 27

Miller v. Jacoby, 145 Wn.2d 65, 33 P.3d 68 (2001) 29

O'Donoghue v. Riggs, 73 Wn.2d 814, 440 P.2d 823 (1968) ... 37

Queen City Farms, Inc. v. Cent. Nat. Ins. Co. of Omaha, 126 Wn.2d 50, 882 P.2d 703 (1994) 28

Reagan v. Newton, 7 Wn. App. 2d 781, 436 P.3d 411 (2019) 27

Reyes v. Yakima Health Dist., 191 Wn.2d 79, 419 P.3d 819 (2018) 25, 26, 27

Rundin v. Sells, 1 Wn.2d 332, 95 P.2d 1023 (1939) 26

State v. Cauthron, 120 Wn.2d 879, 846 P.2d 502 (1993)..... 28

State v. Kirkman, 159 Wn.2d 918, 155 P.3d 125 (2007)..... 29

Stone v. Sisters of Charity of House of Providence, 2 Wn. App. 607, 469 P.2d 229 (1970)..... 26

Swanson v. Brigham, 18 Wn. App. 647, 571 P.2d 217 (1977) 27

White v. Kent Med. Ctr., Inc., P.S., 61 Wn. App. 163, 810 P.2d 4 (1991)..... 32

Young v. Grp. Health Co-op. of Puget Sound, 85 Wn.2d 332, 534 P.2d 1349 (1975)..... 38

Young v. Key Pharm., Inc., 112 Wn.2d 216, 770 P.2d 182 (1989)..... 25, 27

Statutes

RCW 18.79.040..... 33

RCW 18.79.050..... 33

RCW 7.70.030..... 23, 25

RCW 7.70.040..... 26

Rules

ER 702..... 28, 32

RAP 2.5..... 29

Regulations

WAC 246-840-300..... 33, 34

I. INTRODUCTION

This appeal follows the summary judgment dismissal of Appellant Vincent Roberson's claim for medical malpractice. Summary judgment was predicated upon the trial court's determination that Appellant's sole expert witness, an advanced registered nurse practitioner ("ARNP"), was unqualified to establish the standard of care as to the specific medical conditions at issue or to opine on essential components of causation for the Appellant's claimed injuries. In the underlying case, Appellant alleged that he developed an intraabdominal infection and suffered related injuries because a percutaneous endoscopic gastrostomy ("PEG") feeding tube became dislodged, was improperly replaced, and at some point migrated from its proper position in Appellant's stomach. The Court should affirm the decision below where the only witness Appellant could offer as a medical expert (1) lacked any relevant experience or training pertaining to the placement, replacement, or diagnosis of migration with PEG tubes; (2)

lacked the expertise to opine on the radiology and gastroenterology issues necessary to evaluate causation arising from PEG tube complications; and (3) admitted at deposition that her theories of causation were purely speculative and not based on a standard of reasonable medical probability.

II. RESTATEMENT OF ISSUES

1. Do the initials "ARNP" behind a witness's name categorically qualify them as an expert on the standard of care and medical causation related to conditions with which the witness lacks any training or experience and is personally unqualified to treat or diagnose? No.

2. Was expert testimony necessary for Appellant to present a triable medical malpractice claim when this case revolves around locating the specific underlying source of an infectious process, which diagnosis ultimately required advanced medical imaging, and was further complicated by issues of gastroenterology in an already critically ill and complex patient? Yes.

3. Did the trial court properly enter summary judgment when Appellant's sole expert witness lacked experience or training in the placement or replacement of PEG tubes, in treating complications arising from PEG tube migration, or in interpreting the medical imaging used to evaluate the PEG tube's positioning in this case? Yes.

III. RESTATEMENT OF THE CASE

A. Factual Background

On March 12, 2014, Mr. Roberson was admitted to Tacoma General Hospital after being found unresponsive at home. CP 607–16. Mr. Roberson had a medical history of pre-existing quadriparesis from a prior motorcycle accident and he required intubation in the field. *Id.* Mr. Roberson was found to have multifocal airspace disease and, over five days of admission at Tacoma General Hospital, his respiratory status and oxygenation continued to worsen. *Id.* He required high ventilator settings for likely acute respiratory distress syndrome (ARDS). *Id.* On March 19, 2014, a bronchoscopy revealed

MRSA infection in bronchial cultures, demonstrating Mr. Roberson was severely septic, so he was started on the antibiotic Linezolid. *Id.* Mr. Roberson had ongoing fevers, but eventually his sepsis improved. *Id.* Other ICU complications included severe delirium requiring heavy sedation, atypical antipsychotics, and pain medication to facilitate oxygenation. *Id.* Given Mr. Roberson's ongoing respiratory failure, a tracheostomy and PEG tube were placed on April 2, 2014. *Id.* A PEG tube is a feeding tube inserted through the skin and stomach wall directly into the stomach, through which a patient can receive food, medication, and/or nutrients. Mr. Roberson also had a stage 2 pressure ulcer (bedsore) on his right buttock which was clearly documented on April 3, 2014. *Id.* In short, Mr. Roberson was a highly complex patient.

After hospitalization at Tacoma General for over three weeks, on Friday, April 4, 2014, Mr. Roberson was transferred to Regional Hospital, a long-term acute care hospital, for ongoing care with the goal of weaning Mr. Roberson off

ventilator support. CP 618–621, 633–35. It was at this facility where Sound Inpatient Physicians, Inc. became involved with Mr. Roberson's care. On arrival, providers at Regional Hospital ordered an x-ray of his kidneys, ureters, and bladder with contrast ("KUB x-ray") to check his PEG tube position. CP 633–35. They also noted and documented the pre-existing pressure ulcer, still presenting as a stage 2 decubitus. CP 633–35, 637–38. A portable x-ray of Mr. Roberson's abdomen was performed that same day for evaluation of PEG tube placement. CP 640–41. At 3:19 p.m., contrast was injected through the PEG tube and the KUB imaging interpreted by radiologist William Grabowski, MD confirmed that the PEG tube was in position. *Id.*

Later that evening, Mr. Roberson pulled out his PEG tube. CP 643–44. It was replaced by Sound Inpatient Physician, Inc. employee ARNP Heridia, and PEG tube feedings were temporarily discontinued. CP 646 ("peg pulled by patient reinserted by practitioner"). A repeat KUB x-ray with contrast

was ordered to again check the PEG tube replacement, as well as a portable chest x-ray to evaluate diminished breath sounds in the left lung and decreased oxygen saturation. CP 643–44. Both x-rays were taken at 10:14 p.m. *Id.* The chest x-ray was read by radiologist David Alexander, MD at 11:38 p.m. *Id.* Dr. Grabowski read this second KUB x-ray and signed his report of his findings on Saturday, April 5, 2014, at 10:28 a.m. *Id.* Dr. Grabowski described the PEG tube as "again noted within the stomach" and "no abnormal extravasation is seen." His impression as a board-certified and appropriately trained radiologist specifically stated that the "PEG tube [was] in position." *Id.*

On April 5, 2014, at 8:28 a.m., even before Dr. Grabowski completed his interpretation of the April 4 KUB x-ray evaluating the PEG tube reinsertion, yet another portable chest x-ray and KUB x-ray were ordered and taken due to "increasing abdominal distention." CP 648–49. Dr. Grabowski read both films remotely and signed the report of his findings

on these repeat x-rays promptly at 10:58 a.m. *Id.* On the chest x-ray, Dr. Grabowski's impression was that there was "decreased left lower lobe atelectasis and probable unchanged left pleural effusion." *Id.* On the KUB x-ray, he noted that there was air in the colon and moderate distention without evidence of obstruction. *Id.* His impression was that Mr. Roberson had a "moderate colonic ileus." *Id.* Critically, there was no observable change to the PEG tube positioning. *Id.*

In light of Mr. Roberson's increasing abdominal distension, abnormal vital signs (including elevated temperature), and the repeated KUB x-ray imaging showing the PEG tube was still in place, a gastroenterology consult was sought that same day (April 5, 2014). CP 651–53, 656–57. Mr. Roberson was carefully monitored by nursing staff over the remainder of the weekend while awaiting follow-up gastroenterology consultation. *Id.* By Monday, April 7, 2014, it was also clearly documented that the Regional Hospital providers had recognized and diagnosed Mr. Roberson with

"severe sepsis," and were actively working to identify and resolve the underlying cause. CP 658. Accordingly, a plan was made and documented that if the forthcoming abdominal ultrasound and consult by a GI specialist was inconclusive as to a gastroenterological cause or source of the infection, further advanced abdominal CT imaging would be pursued. *Id.* That day, gastroenterologist Michael Kramer, MD saw Mr. Roberson for evaluation and performed an abdominal ultrasound. CP 655–54. There was no indication on the abdominal ultrasound that the PEG tube had migrated or become displaced. *Id.* To the contrary, the imaging showed only non-specific "small ascites[1]" in the abdomen, as opposed to the large volume that would be expected after a prolonged period with a displaced PEG tube. *See id.* Based on his evaluation, Dr. Kramer diagnosed Mr. Roberson with liver shock due to the patient's history of

[1] The term "ascites" refers to fluid collecting in spaces within the abdomen, commonly associated with liver failure or disease.

hypoperfusion,[2] and noted in particular that the condition was expected to resolve but should be monitored. *Id.*

On April 8, 2014, Mr. Roberson remained septic, and in light of the ongoing unexplained sepsis and worsening hematologic markers, CT imaging was ordered consistent with the preestablished plan of care. CP 662. On April 9, 2014, the abdominal pelvic CT was interpreted by radiologist Peter Ory, MD, which revealed that the PEG tube had migrated. CP 664–66. In comparison to the small ascites observable on ultrasound imaging the previous day on April 7, 2014, this later imaging now demonstrated "large volume ascites" consistent with PEG tube displacement. CP 665. These results were relayed to ARNP Heridia, and Mr. Roberson was immediately transferred back to Tacoma General Hospital where he underwent surgery to remove the fluid from his abdominal cavity. *See* CP 665.

[2] The term "hypoperfusion" means reduced blood flow. "Liver shock" is damage or injury to the liver due to reduced blood or oxygen supply to the liver.

B. Litigation Background

Mr. Roberson filed his original complaint on March 22, 2017, in Kitsap County Superior Court against Defendants CHI; Franciscan; Regional Hospital; Embra Arthur Roper, M.D.; Coriander Heridia, ARNP; Sound Inpatient Physicians; P. Garrett, ARNP; Clarence Michael Kramer, M.D.; and radiologist William Grabowski, M.D. CP 2–11.

1. Dr. Kramer and Dr. Grabowski Prevail on Summary Judgment

After Mr. Roberson filed this action, dispositive motions were filed by the defendant specialists Clarence Michael Kramer, MD and William Grabowski, MD, citing Mr. Roberson's lack of qualified expert testimony to support criticisms of their care. CP 128–38, 149–58. In opposition to these motions, Mr. Roberson submitted the declaration of his sole medical expert, Cheryl Hahn, ARNP. CP 163–69. In that declaration, ARNP Hahn articulated the central underlying theory of Mr. Roberson's claim for injuries and her opinions as follows:

> There are really two distinct "injuries" in this case. The first is the improper reinsertion of the PEG tube, which occurred on the evening of Mr. Roberson's first night at Regional Hospital. The second form of injury occurred as the condition (migrated PEG tube) remained undiagnosed and feeding was not only continued but increased.

CP 166. Based on this, she opined that "[t]he negligent mis-insertion of the PEG tube and following negligence in continuing to feed Mr. Roberson through the PEG tube, failure to diagnose the conditions caused by nutrients being fed into the peritoneal cavity, and failure to respond to symptoms of sepsis led to injuries all caused by the negligence of each and all named Defendants." CP 169. ARNP Hahn's declaration also expressly acknowledged "she may not be competent to give testimony on the standard of care with a particular doctor's specialty," including radiology and gastroenterology. CP 164. Instead, she claimed that by virtue of her unspecified "background and experience as an ARNP," she was qualified to opine in this case on any aspect of "primary care." CP 164.

In reply, Dr. Grabowski and Dr. Kramer explained how ARNP Hahn, with her nurse practitioner experience, was not qualified to opine as to the standard of care or causation pertaining to gastroenterology and radiology specialist physicians. CP 536–42. On August 27, 2017, after evaluating ARNP Hahn's declaration and Mr. Roberson's opposition to the summary judgment motions, the Court agreed with the specialist physicians' arguments and dismissed Mr. Roberson's claims against them as lacking in competent expert testimony. CP 569–574.

2. ARNP Hahn's Deposition Reveals She Lacks Foundational Expertise or an Underlying Factual Basis for Her Opinions

After continuances to the case schedule, the remaining parties conducted the deposition of ARNP Hahn on September 17, 2020. CP 676. At deposition, ARNP Hahn discussed in detail how her theory of the case was predicated on her opinion that Mr. Roberson's PEG tube had migrated because it was not properly reinserted on April 5, 2014:

> Q. Why do you believe that the PEG tube reinsertion on April 5th was below the standard of care?
>
> A. Because it was done blindly, and there was no record to say why the tube came out. So we don't know, because she just put it back in, what the tube looked like or what the site looked like. We don't know what led up to it. So it was basically a blind insertion.
>
> . . .
>
> Q. And then, so it's your opinion that there should have been some imaging occurring while the tube placement took place?
>
> A. Yes.

CP 687–690. However, on further questioning, ARNP Hahn explained how her theory of "negligent" PEG tube reinsertion was in fact predicated on her *inability* to determine from the medical records whether the patient's PEG tube was properly located back into the stomach after reinsertion:

> Q. Do you agree that when that tube was reinserted that it was placed into the stomach?
>
> A. When the person did it, put it back in?
>
> Q. Correct.

> A. You know, that's where—that's the problem is that we don't know where that person put it.

CP 683. Furthermore, based on her suspicion that some complication may have occurred when the PEG tube was replaced, ARNP Hahn opined that the PEG tube became dislodged from the stomach soon after on that same day:

> Q. So is it your opinion, then, that as of some point a couple of hours after reinsertion of the PEG tube that it migrated a couple of hours later on April 5th? Do I understand that correctly?
>
> A. Yes.

CP 685.

However, when ARNP Hahn was questioned as the foundation of these opinions, it was revealed that her opinions lacked foundational expertise for numerous critical aspects of her theories, and even lacked an underlying factual basis. When questioned about the expertise of an ARNP such as herself to place PEG tubes, she personally was unaware of what requisite qualifications might exist for an ARNP to perform such a procedure:

> Q. Are you aware of whether nurse practitioners are qualified to insert the PEG tube?
>
> A. You know, that I don't know. It depends on what practice you're in. If they're a GI specialist, sure, they probably can do it, but the everyday nurse practitioner walking in, no.
>
> Q. So it depends on the level of the nurse practitioner's experience and training?
>
> A. Yes.
>
> Q. And there's no special licensure or certification to place a PEG tube by an ARNP; correct?
>
> A. Correct.

CP 686. In turn, when discussing her own personal training and experience with the relevant medical issues and problems in this case, she acknowledged that her area of ARNP practice was podiatry, and that she had never placed or replaced a PEG tube in her entire career:

> Q. And what is your role at Polyclinic?
>
> A. I work in the podiatry department as a nurse practitioner.
>
> Q. Is that full time?
>
> A. Yes.

Q. And prior to that where did you work?

A. I worked about, oh, less than six months at Northwest Hospital in their palliative care unit, which they dissolved when the U-Dub bought them. And then I worked a year at the Seattle Cancer Care Alliance in the sarcoma clinic. Hated it; so I quit. And then before I worked for six years at the VA where I ran a wound care clinic.

Q. And I see that—let's unpack that piece by piece here. The Northwest Hospital position, you said six months in the palliative and supportive care field?

A. Yes.

Q. Did any of that involve dealing with PEG tubes?

A. Yes.

Q. Were you placing them?

A. No.

Q. Have you ever placed them in your career?

A. No.

CP 677–78. When asked to describe what limited familiarity and exposure she actually had to PEG tubes as an ARNP, ARNP Hahn acknowledged it was limited to the simple knowledge of whether or not the patients she saw had one:

> Q. What was your involvement with PEG tubes at Northwest Hospital and the sarcoma clinic?
>
> A. Basically, I knew whether they had them or not. And then when you did an assessment, you know, that was part of the assessment, when you got to the GI, is were they there, was it there, how was it secured.

CP 678. Indeed, when pressed on what specific involvement she might ever have had with PEG tube placement or replacement as an ARNP, ARNP Hahn acknowledged it was limited to *transporting* patients to other specialist providers, like radiologists:

> Q. In any job you've had either as a nurse or a nurse practitioner, have you been involved in the placement of PEG tubes?
>
> A. I didn't personally place them, but I took them to the radiologist to have it done. Transported patients down there.

CP 678. Perhaps most surprisingly, when asked what the term "PEG tube" means, she was unable to answer. *Id.* at 18:4–5 (Q. Do you know what "PEG" stands for? A. Not off the top of my head.").

ARNP Hahn was also questioned further as to the factual foundation for the central component underlying her opinions on the patient's management and causation—namely, that Mr. Roberson's PEG tube had migrated within hours after replacement on April 5, 2014. When confronted with the fact that medical imaging demonstrated that the PEG tube was indeed properly replaced back into the stomach April 5, 2014, ARNP Hahn revised her prior testimony and underlying foundation for her opinions, admitting that the PEG tube was in fact reinserted into the stomach:

> Q. Okay. Well, was a KUB ordered to determine whether it was properly placed into the stomach?
>
> A. Yes.
>
> Q. Was that run by Dr. Grabowski?
>
> A. I believe so, yes.
>
> Q. Dr. Grabowski determined as a radiologist that the PEG tube was properly in the stomach; correct?
>
> A. Yes.
>
> Q. And that was on April 5th; right?

A. Yes.

Q. And the nurse practitioners have a right to rely on the radiologist interpretation; correct?

A. Yes.

Q. Are you claiming that Dr. Grabowski, his interpretation is incorrect, that the tube was not placed in the stomach?

A. No.

CP 683–684. ARNP Hahn then conceded that the PEG tube was in fact placed back into the stomach:

Q. But would you agree that the tube did go into the stomach—correct?—

A. Yes.

Q.—whether it was blind or not. Right?

A. (Nodding head.)

Q. Is that a yes?

A. Yes. I'm sorry, yes.

CP 688.

Even in the absence of such an admission, ARNP Hahn lacked the necessary qualifications to contradict the radiology

findings showing that Mr. Roberson's PEG tube was in fact reinserted into the proper position:

> Q. Okay. Is a nurse practitioner qualified to read a KUB film?
>
> A. Yes.
>
> Q. Is that something that you would do as a matter of record? Would you chart "I reviewed the film" — "the KUB film, and this is what I saw"?
>
> A. You can say you can review it, yes, but you have to rely on the radiologist to confirm what's going on. You don't make it yourself, but you look at it.
>
> Q. Okay. What is the training that you had to—strike that. Are you qualified to interpret KUB films?
>
> A. No.
>
> Q. So as a nurse practitioner, is it fair for me to say that you would rely on a radiologist interpretation of a film?
>
> A. Yes.
>
> Q. Including a KUB?
>
> A. Yes.

CP 680–81. Moreover, when examined as to the factual basis for her opinion on what caused the PEG tube to migrate and

when such migration occurred, ARNP Hahn explained how her theory of causation was speculation predicated on her *inability* to actually determine what caused the PEG tube migration:

> Q. And how would that have made any difference in the placement of the tube in this particular case?
>
> A. Because we don't know the trauma of the tissue when the tube came out. So the tissue surrounding and where it entered into the body underneath *could* have been damaged. It *could* have been ripped. It *could* have been—made a hole in it. *And so we don't know*. And that's where—putting it blind is you don't know what happened to—what took place with the tissue as it came out and when it went back in.
>
> Q. So are you going to be offering an opinion at trial as to what happened to the tissue when the tube came out on April 4th?
>
> A. My opinion will be that there *could* have been damage to the tissue, yes.
>
> . . .
>
> Q. What else could have caused it?
>
> A. Beats me.

CP 689–90 (emphasis added). ARNP Hahn even agreed that her theory was purely "speculation":

> Q. So now we're back to where I think we were before. If you don't know whether there was any injury to the tissue, you cannot say, with reasonable medical probability, that there was injury to the tissue; isn't that true? You just don't know?
>
> A. That's probably closer to—because I think you're asking me to speculate. Yeah.

CP 698.

3. Sound Inpatient Physicians, Inc. Prevails on Summary Judgment

Based on ARNP Hahn's deposition testimony, on November 16, 2021, Sound Inpatient Physicians, Inc. moved for summary judgment, asserting that Mr. Roberson lacked qualified expert testimony to support his malpractice claim. Specifically, Sound Inpatient Physician's, Inc. argued that Mr. Roberson's sole expert witness, ARNP Hahn, was unqualified to opine on essential elements of the standard of care and causation pertaining to PEG tube placement, replacement, and diagnosis of migration. At the time of summary judgment, the only agent of Defendant Sound Inpatient Physicians, Inc. identified by Plaintiff whose medical care remained subject to

criticism was ARNP Heridia, who Mr. Roberson had voluntarily dismissed on an individual basis on July 20, 2020 while retaining claims of vicarious liability.

In response to the motion, Mr. Roberson reincorporated the prior submitted declaration of ARNP Hahn and continued to offer only ARNP Hahn as his sole medical expert witness. *See* CP 701–19.

At hearing, Judge William C. Houser of Kitsap County Superior Court determined that ARNP Hahn was indeed unqualified to opine on critical elements of Mr. Roberson's case and entered summary judgment. CP 1042–44. This appeal follows.

IV. ARGUMENT

Competent testimony by a qualified expert witness is necessary to establish the essential elements of a medical malpractice claim under RCW 7.70.030. For a witness to be qualified to offer expert medical opinions, the witness must possess sufficient expertise in the relevant specialty and area of

medicine. This requires a case-by-case evaluation of whether a witness possesses sufficient expertise to demonstrate familiarity with the procedure or medical problem at issue. Here, the trial court correctly entered summary judgment because Appellant's sole expert witness was unqualified to opine on critical components of either the standard of care or issues of medical causation specifically at issue in this case. Moreover, in discussing essential issues of medical causation, Appellant's expert acknowledged that her opinions were purely speculative. The Court of Appeals should affirm the decision below.

A. Competent Expert Testimony Was an Essential Element to Support Appellant's Claim of Medical Malpractice

It is well established that a plaintiff's failure to produce qualified, competent expert testimony in a claim for medical malpractice will result in summary judgment dismissal. Summary judgment is appropriate under CR 56(c) where "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." A moving

defendant may meet the initial burden of showing the absence of a material fact by simply pointing out there is an absence of evidence to support the non-moving party's case. *Young v. Key Pharm., Inc.*, 112 Wn.2d 216, 225–26, 770 P.2d 182 (1989); *Guile v. Ballard Cmty. Hosp.*, 70 Wn. App. 18, 21, 851 P.2d 689 (1993).

Specific to claims of medical malpractice, a plaintiff must oppose summary judgment by presenting evidence to support each essential element for one of the enumerated theories of malpractice under RCW 7.70.030. *Reyes v. Yakima Health Dist.*, 191 Wn.2d 79, 86–87, 419 P.3d 819 (2018). *See also Branom v. State*, 94 Wn. App. 964, 969, 974 P.2d 335 (1999) ("[W]henever an injury occurs as a result of health care, the action for damages for that injury is governed exclusively by RCW 7.70. We also conclude that the specific question of whether the injury is actionable is governed by RCW 7.70.030."). Specific to claims that a health care provider has breached an applicable standard of medical care, as in this case,

a plaintiff must show that "[t]he health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances." RCW 7.70.040(1)(a). Furthermore, a plaintiff must show that "[s]uch failure was a proximate cause of the injury complained of." RCW 7.70.040(1)(b). "[M]alpractice cannot be inferred from a bad result." *Rundin v. Sells*, 1 Wn.2d 332, 334, 95 P.2d 1023 (1939).

The evidence supporting the essential elements of a claim under RCW 7.70 must consist of qualified, competent expert testimony. *Reyes*, 191 Wn.2d at 86. *See also Stone v. Sisters of Charity of House of Providence*, 2 Wn. App. 607, 611, 469 P.2d 229 (1970) ("[E]xpert testimony is essential to a showing of an act or omission by the defendant which breaches a standard of care owed by him to the plaintiff, which breach is the cause, both in fact and proximately, of damage to the plaintiff.")

(quotation omitted). This "requires an expert to say what a reasonable doctor would or would not have done, that the defendants failed to act in that manner, and that this failure caused the injuries." *Reyes*, 191 Wn.2d 86–87. "If the plaintiff lacks expert testimony regarding one of the required elements, the defendant is entitled to summary judgment on liability." *Reagan v. Newton*, 7 Wn. App. 2d 781, 791, 436 P.3d 411 (2019).

This requirement that expert testimony be produced in opposition to summary judgment is further subject to the necessity that such testimony actually be competent. *McKee v. Am. Home Prod. Corp.*, 113 Wn.2d 701, 706–07, 782 P.2d 1045 (1989) (citing *Young*, 112 Wn.2d at 227–30); *Swanson v. Brigham*, 18 Wn. App. 647, 571 P.2d 217 (1977) ("Absent special exceptions, a plaintiff patient must establish the standard of professional practice at the time of the alleged injury and a violation of that standard, through the testimony of the professional equals of the defendant physician.").

Washington courts have repeatedly emphasized that "[a]n expert must stay within the area of his expertise." *Queen City Farms, Inc. v. Cent. Nat. Ins. Co. of Omaha*, 126 Wn.2d 50, 102, 882 P.2d 703 (1994). This arises from the evidentiary rule that, "[t]o admit expert testimony under ER 702[,] the trial court must determine that the witness qualifies as an expert and the testimony will assist the trier of fact." *State v. Cauthron*, 120 Wn.2d 879, 887, 846 P.2d 502 (1993), *overruled in part on other grounds by State v. Buckner*, 133 Wn.2d 63, 941 P.2d 667 (1997). Indeed, "[t]he expert's qualification to render medical opinions on the standard of care in Washington State is as important an element in a medical malpractice case as the factual basis on which the expert supports his opinion." *Boyer v. Morimoto*, 10 Wn. App. 2d 506, 526, 449 P.3d 285 (2019).

The Court should reject Appellant's contention that competent expert testimony was unnecessary to establish the standard of care or medical causation for this case. *See* Appellant's Opening Brief at 28–31. First, Appellant failed to

make any such argument below. *See* CP 701–19. "The general rule is that appellate courts will not consider issues raised for the first time on appeal." *State v. Kirkman*, 159 Wn.2d 918, 926, 155 P.3d 125 (2007); RAP 2.5. Appellant does not argue and cannot recite any circumstances suggesting this new argument falls under the exceptions to the general rule contemplated in RAP 2.5(a). Raised for the first time on appeal, this issue is procedurally barred and not properly before the Court.

Even if considered, Appellant's argument lacks substantive legal merit. A claimant may proceed without expert testimony in a medical malpractice action only "[w]hen medical facts are observable by a layperson's senses and describable without medical training." *Miller v. Jacoby*, 145 Wn.2d 65, 72, 33 P.3d 68 (2001). *See also Frausto v. Yakima HMA, LLC*, 188 Wn.2d 227, 232, 393 P.3d 776 (2017) ("Like the standard of care, expert testimony is always required except in those few situations where understanding causation "does not require

technical medical expertise."). A jury could not understand the standard of care in this case for diagnosing a specific underlying source of infection in a complex and already critically ill patient without the aid of competent expert testimony—particularly when such diagnosis ultimately required advanced medical imaging to evaluate the internal positioning of the patient's PEG tube. Nor could a jury on its own understand what events can cause a PEG tube to migrate, the various complications that can cause nutrients from a PEG tube to leak into the peritoneal cavity (even when properly positioned), how drainage from a PEG tube's insertion site into the stomach relates to the many possible factors involved with the spread of infection in an already ill patient, or how subsequent medical care relates to the cause of claimed injuries like the patient's bedsores.

B. A Witness's Qualification to Offer Expert Medical Testimony is Determined by the Witness's Personal Training and Experience

Central to this appeal is Appellant's mistaken argument that nurse practitioners, by virtue of their licensing, are categorically qualified to offer broad expert testimony on any medical issue, regardless of personal experience and training. *See* Appellant's Opening Brief at 13–16. However, Washington law rejects the contention that a witness's relevant expertise can be determined per se by the initials following an expert's name. *Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 450, 663 P.2d 113 (1983); *Frausto*, 188 Wn.2d at 238. Instead, a particular witness's qualification to offer medical expert testimony "is governed by our Rules of Evidence and requires a case by case inquiry." *Frausto*, 188 Wn.2d at 238.

Specific to allegations of medical malpractice, when determining whether a witness has the foundation to address a particular medical question, "courts must consider whether the expert has 'sufficient expertise in the relevant specialty.'" *L.M.*

by & through Dussault v. Hamilton, 193 Wn.2d 113, 135, 436 P.3d 803 (2019) (quoting *Frausto*, 188 Wn.2d at 232). Moreover, a medical expert opining on a particular procedure must show "sufficient expertise to demonstrate familiarity with the procedure or medical problem at issue." *White v. Kent Med. Ctr., Inc., P.S.*, 61 Wn. App. 163, 173, 810 P.2d 4 (1991). Accordingly, while a nurse practitioner "*may* be qualified to testify regarding causation in a medical malpractice case if the trial court determines that the ARNP meets the threshold requirements of ER 702," *Frausto*, 188 Wn.2d at 229 (emphasis added), it will only be authorized where the trial court makes a careful determination that the nurse indeed possesses "sufficient expertise in the relevant specialty such that the expert is familiar with the procedure or medical problem at issue." *Id.* at 232.

Appellant's argument that ARNP Hahn is qualified to offer opinions as an expert in this case relies exclusively on her ARNP license and the maximum scope of a nurse practitioner

practice allowable under Washington statutory and regulatory authority. *See* Appellant's Opening Brief at 13–15, 35 (citing RCW 18.79.040(1)(a); RCW 18.79.050; WAC 246-840-300(1), (5)(a), (5)(c), 5(e)). Specifically, Appellant argues:

> Appellant argues that, if an ARNP is authorized, specifically, to perform this kind of care, by the legislature, then the Court must accept that an ARNP is, as a matter of law, qualified to give testimony on a standard of care consistent with this list and whether that standard was breached. Because the statute is clear on its face, is would be an error of law to find otherwise.

Appellant's Opening Brief at 16.

However, the broad scope of allowable practices and procedures for qualified nurse practitioners with relevant expertise does not qualify ARNP Hahn as an expert on medical problems for which she personally lacks training or experience. Indeed, under the express terms of the regulatory scheme cited by Appellant, such an argument fails. The regulatory authority cited by Appellant states in definite terms that "[t]he ARNP functions within his or her scope of practice," WAC 246-840-

300(3), and must "obtain instruction, supervision, and consultation as necessary before implementing new or unfamiliar techniques or practices." WAC 246-840-300(4). Critically, an ARNP can perform functions listed under the regulations cited by Appellant *only* if undertaken "within the scope of the ARNP's knowledge, experience and practice." WAC 246-840-300(5). Accordingly, even under the regulatory scheme cited by Appellant, an ARNP's qualifications on any medical topic are subject to a case-by-case assessment of the ARNP's personal "knowledge, experience, and practice," and broad claims of "per se" expertise due to an ARNP's licensure must be rejected.

C. Appellant's Sole Expert Witness was Unqualified to Opine on Essential Components of the Standard of Care or Medical Causation Specific to this Case

The trial court properly determined that ARNP Hahn was unqualified to opine on the standard of care or medical causation as to the specific medical problems at issue in this case. Whether ARNP Hahn was qualified to offer expert

testimony on specific topics is appropriately within the purview of the trial court. *Frausto*, 188 Wn.2d at 239, 242 ("Decisions on the qualifications of expert testimony—whether an expert has the proper foundation for their opinions—remains a function of the court."). The trial court's determination can only be reversed for manifest abuse of discretion. *Harris*, 99 Wn.2d at 450 ("Trial courts retain broad discretion in determining whether an expert is qualified and will be reversed only for manifest abuse.").

The record supports the trial court's determination that ARNP Hahn lacks the knowledge, experience, and practice to offer expert testimony on essential components of Appellant's malpractice claim. Despite ARNP Hahn's own statements that her theory of the case was focused on PEG tube placement, replacement, and diagnosis of migration, discovery revealed she has no experience or training in these topics. She has never placed a PEG tube. CP 677–78. While acknowledging than an ARNP (such as ARNP Heridia) might be qualified based on

their personal training and experience, ARNP Hahn admitted that she does not even know if an ARNP (such as herself) can be qualified to perform a PEG tube replacement. CP 686. ARNP Hahn described her own personal lack of experience and training with PEG tubes as follows: "Basically, I knew whether they had them or not." CP 678. ARNP Hahn did not even know what the term "PEG tube" means. CP 682 ("Q. Do you know what 'PEG' stands for? A. Not off the top of my head."). ARNP Hahn further admitted to being unqualified to interpret the medical imaging necessary to determine if a PEG tube is in its proper place. CP 680–81. Consistent with this lack of expertise, ARNP Hahn admitted she was unable to dispute that, when checked on three separate occasions after replacement, the PEG tube was properly positioned according to the specialists interpreting the imaging. CP 683–84.

Lacking any experience, training, or knowledge as to the relevant topics of PEG tube placement, replacement, migration, and diagnosis, and being unable to interpret or contradict the

repeated medical imaging or associated radiology reports demonstrating that Mr. Roberson's PEG tube was properly positioned after its reinsertion on April 5, 2014, ARNP Hahn was plainly unqualified to offer opinions on the standard of care for evaluating and diagnosing a migrated PEG tube or key medical facts of causation pertaining to the reason for and timing of the PEG tube's ultimate migration.

D. Appellant's Sole Expert Witness Admitted that Her Theory of Medical Causation was Purely Speculative and Lacked a Factual Basis

As an independent basis to affirm, summary judgment was appropriate because ARNP Hahn's deposition testimony made clear that her theory as to medical causation revolving around the PEG tube's migration was purely speculative. For expert testimony to support medical causation, the evidence must be more than mere assertions that the alleged acts of the defendant "might have", "may have", "could have", or "possibly did" cause the injury. *O'Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968); *Young v. Grp. Health*

Co-op. of Puget Sound, 85 Wn.2d 332, 340, 534 P.2d 1349 (1975).

Even if ARNP Hahn were somehow qualified to opine as an expert witness on the medical problems specific to this case, she testified at deposition that she could only speculate as to the medical facts underlying her theory of what caused the PEG tube to migrate:

> Q. And how would that have made any difference in the placement of the tube in this particular case?
>
> A. Because we don't know the trauma of the tissue when the tube came out. So the tissue surrounding and where it entered into the body underneath *could* have been damaged. It *could* have been ripped. It *could* have been—made a hole in it. *And so we don't know*. And that's where—putting it blind is you don't know what happened to—what took place with the tissue as it came out and when it went back in.
>
> Q. So are you going to be offering an opinion at trial as to what happened to the tissue when the tube came out on April 4th?
>
> A. My opinion will be that there *could* have been damage to the tissue, yes.
>
> . . .

Q. What else could have caused it?

A. Beats me.

CP 689–90 (emphasis added). ARNP Hahn even explicitly agreed that her theory lacked "reasonable medical probability" and was appropriately characterized as "speculation." CP 698. (Q. . . . [Y]ou cannot say, with reasonable medical probability, that there was injury to the tissue; isn't that true? You just don't know? A. That's probably closer to—because I think you're asking me to speculate. Yeah.").

Moreover, the medical record plainly controverts ARNP Hahn's central causation theory that the PEG tube migrated within several hours after replacement on April 5, 2014, and that providers failed to diagnose this as the source of the infection. Because Regional Hospital providers recognized Mr. Roberson was experiencing signs and symptoms of some form of infection, Mr. Roberson received repeated imaging that confirmed the PEG tube was properly positioned. CP 640–44, 648–49. Moreover, after KUB imaging confirmed the PEG tube

was appropriately positioned, Mr. Roberson was seen by a qualified gastroenterologist, Michael Kramer, MD, who had an abdominal ultrasound performed that "revealed obesity and a fatty liver but no other abnormalities." CP 651–53, 656–57. As Mr. Roberson's condition worsened on April 8, 2014, additional CT imaging was ordered which showed PEG tube migration and large volume ascites in the peritoneal cavity—findings that were not present on the repeated earlier medical imaging showing the PEG tube in proper position. CP 655–54, 658.

Accordingly, even if ARNP Hahn were somehow qualified to opine on the medical problems specific to this case, her causation theory lacks a factual foundation where imaging confirmed the PEG tube was properly positioned after the time that ARNP Hahn speculated that the PEG tube had migrated, and the subsequent imaging that did demonstrate PEG tube migration included associated findings that were specifically absent from the prior imaging or specialist consultations.

V. CONCLUSION

Based on the foregoing, Respondent Sound Inpatient Physicians, Inc. respectfully requests that the Court affirm the decision below. Appellant's medical malpractice claim necessarily fails without supporting testimony from a qualified expert. Appellant cannot demonstrate manifest abuse of discretion in the trial court's determination that Appellant's sole witness offered as an expert was unqualified to opine on the standard of care or critical components of causation in this case. Moreover, even if Appellant's sole medical witness was qualified as an expert in the relevant medical problems, that witness's opinions lacked factual foundation and the witness herself admitted that causation was purely speculative.

The undersigned certifies this document contains 6,657 words in compliance with RAP 18.17(c).

DATED this 1st day of August, 2022, at Tacoma, Washington.

JOHNSON, GRAFFE, KEAY, MONIZ & WICK, LLP

s/ Brennen Johnson
Brennen Johnson, WSBA #51665
Attorney for Sound Inpatient Physicians, Inc.
2115 N 30th St., Ste. 101
Tacoma, WA 98403
(253) 572-5323
brennenj@jgkmw.com

VI. CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury under the laws of the State of Washington that the following is true and correct. On the date signed below, I caused to be served in the manner indicated a true and accurate copy of the foregoing, BRIEF OF RESPONDENT SOUND INPATIENT PHYSICIANS, INC., by the method indicated below and addressed to the following:

Counsel for Appellant Chalmers C. Johnson, WSBA # 40180 Longshot Law, Inc. PO Box 1575 Port Orchard, WA 98366 chalmersjohnson@gmail.com longshot3@gmail.com	☐ U.S. Mail ☐ Hand Delivery ☐ Facsimile ☑ E-mail/E-Service ☐ Messenger

Counsel for Co-Respondents Miranda Kathryn Aye Michelle Suzanne Taft 925 4th Ave, Ste 2300 Seattle, WA 98104-1145 AyeM@jgkmw.com TaftM@jgkmw.com Bruce W. Megard Bennett Bigelow & Leedom, PS 601 Union St Ste 1500 Seattle, WA 98101-1363 eseeperger@bbllaw.com bmegard@bbllaw.com Howard Mark Goodfriend Catherine Wright Smith Smith Goodfriend PS 1619 8th Ave. N Seattle, WA 98109-3007 howard@washingtonappeals.com cate@washingtonappeals.com	☐ U.S. Mail ☐ Hand Delivery ☐Facsimile ☑ E-mail/E-Service ☐ Messenger

Signed this 1st day of August, 2022 at Phoenix, Arizona.

/s/ Sandra Cameron
Sandra Cameron, Legal Assistant

JOHNSON GRAFFE KEAY MONIZ & WICK

August 01, 2022 - 12:21 PM

Transmittal Information

Filed with Court:	Court of Appeals Division II
Appellate Court Case Number:	56768-7
Appellate Court Case Title:	Vincent Roberson, Appellant/Cross Respondent v. CHI Franciscan, et al., Respondents/Cross-Appellants
Superior Court Case Number:	17-2-00485-7

The following documents have been uploaded:

- 567687_Briefs_20220801121029D2804376_0951.pdf
  This File Contains:
  Briefs - Respondents
  The Original File Name was Brief of Respondent Sound Inpatient Physicians Inc.pdf

A copy of the uploaded files will be sent to:

- Miranda@jgkmw.com
- andrienne@washingtonappeals.com
- bmegard@bbllaw.com
- cate@washingtonappeals.com
- chalmers@longshotlaw.com
- chalmersjohnson@gmail.com
- howard@washingtonappeals.com
- kcalkins@bbllaw.com
- michelle@jgkmw.com
- phild@jgkmw.com
- taftm@jgkmw.com

Comments:

Sender Name: Sandra Cameron - Email: sandra@jgkmw.com
Filing on Behalf of: Brennen Jordan Johnson - Email: brennenj@jgkmw.com (Alternate Email:)

Address:
925 4th Ave
Suite 2300
Seattle, WA, 98104
Phone: (206) 223-4770

Note: The Filing Id is 20220801121029D2804376